

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH-

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009976

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 319 Primary Registration District No. _____ Registrar's No. 11VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u>		Length of stay in 1b <u>21 yrs</u>	c. CITY OR TOWN <u>NEW OFFENBURG</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NEW OFFENBURG</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>STE. GENEVIEVE CO.</u>
3. NAME OF DECEASED (Type or print) First <u>ORPHA</u> Middle <u>MUSCOGEE</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/1986</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>64</u>
11a. FATHER'S NAME <u>THOMAS COLLINS</u>		11b. MOTHER'S MAIDEN NAME <u>NELLIE COLLINS</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>THOMAS COLLINS</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES L. JOHNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT <u>James L. Johnson New Offenburg MO</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) <u>Arteriosclerotic Ht. Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>1957</u> to <u>Mar 1, 1963</u> and last saw her alive on <u>Feb 25, 1963</u>		Death occurred at <u>NEW OFFENBURG MO</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>R. A. Hubert</u> (Degree or title)		22b. ADDRESS <u>Farmington, MO</u>	22c. DATE SIGNED <u>3/2/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3/3/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WINDS MEMORIAL PARK FREDERICKTOWN</u>	23d. LOCATION (City, town, or county) <u>MO</u>
24. FUNERAL DIRECTOR <u>Geo C. Baerle Ste. Genevieve Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6 March 1963</u>	26. REGISTRAR'S SIGNATURE <u>George L. Wood</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

USE

MAR 19 1963

MAR 14 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Adrian J. Ellis

Licensed Embalmer No. 4740

P. O. Address St. Denewine, Md.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.